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ABSTRACT

Begun in 1993, a 5-year project examined treatment modalities and outcomes and counselor and client attitudes related to American Indian or Alaska Native vocational rehabilitation (VR) clients with alcoholism or substance abuse problems. Specifically, surveys and focus groups examined elements of successful substance abuse treatment and VR programs, areas of social-cognitive dissonance between VR counselors and their clients, and the use of culturally relevant treatment modalities different from those used in mainstream programs. A 1993 survey of 31 "exemplary" substance abuse treatment centers recommended by VR counselors, and a 1996 followup survey of 14 of these centers found that most centers extensively incorporated American Indian personnel and cultural practices into the treatment process, but success rates over 50 percent were rare. In the followup survey, all programs based "most" or "some" of their treatment methodology on Alcoholics Anonymous (AA). Treatment orientations based on Native American traditional healing did not claim better success rates than other orientations. Counselor and client focus groups in Texas, New Mexico, and Arizona discussed eligibility for VR services, effects of the substance abuse problem and state of recovery on the VR process, client motivations, training needs, and factors contributing to or impeding recovery. Areas of congruence and disparity in counselor and client attitudes are discussed. Recommendations are presented for VR counselor training and program improvement, and the 12 steps of AA are listed. (SAS)

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The Vocational Rehabilitation of American Indians Who Have Alcohol or Drug Abuse Disorders

EXECUTIVE SUMMARY
1997

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The Vocational Rehabilitation of American Indians Who Have Alcohol or Drug Abuse Disorders

In 1993, the American Indian Rehabilitation Research and Training Center (AIRRTC) conducted a survey of vocational rehabilitation (VR) counselors who worked with American Indians and Alaska Natives with alcoholism or drug abuse disabilities (Schacht & Gaseoma, 1993). A 5-year research and training project was then proposed as part of the AIRRTC's Competitive Application for 1993–1998. This project, numbered R-36, was entitled, *The Vocational Rehabilitation of American Indians Who Have Alcohol or Drug Abuse Disorders*. The propose of this project was to (a) identify and analyze the effective components of successful substance abuse treatment and VR programs, (b) identify areas of social-cognitive dissonance between VR counselors and their clients that serve as obstacles to successful rehabilitation, and (c) examine the use of effective, culturally relevant treatment modalities different from those used in mainstream treatment programs.

Accordingly, a treatment center survey was conducted in 1993, and a shorter follow-up survey was conducted in 1996. Next, information from VR counselors who worked with American Indians with alcoholism or drug problems was collected by written questionnaires and focus groups. Then information was obtained from American Indian VR clients, again using both questionnaires and focus groups. The information collected from VR counselors and clients was matched to compare and contrast attitudes of counselors and clients on similar issues. However, the clients who responded were not necessarily clients of the VR

counselors who responded, so the contrast in attitudes could not be precisely controlled.

The research findings are summarized under the headings of Treatment Center Surveys, Counselor Focus Groups, Counselor Survey, Client Focus Groups, and Client Survey. The methods, results, and conclusions of the research activity are described in each of these sections.

Treatment Center Survey

Five types of treatment models used for American Indians who have alcohol and other substance abuse disorders have been identified: the Medical Model, the Psychosocial Model, the Assimilative Model, the Culture-Sensitive Model, and the Syncretic Model (Weibel-Orlando, 1989). These range from the Anglo orientation exemplified by the Medical Model—with an all-Anglo staff, strong AA orientation, counselors with university degrees who treat alcoholism as a medical disease, little or no cultural accommodations, and no cooperation with Indian healers—to a mostly Indian orientation (the Syncretic Model).

An example of the Syncretic Model might be the Red Road Approach (Arbogast, 1995), which uses the medicine wheel as a central concept. Another indigenous treatment modality for alcoholism involves using a sweat lodge (Hall, 1986). Leland (1980) discussed American Indian objections to the Alcoholics Anonymous (AA) format, observing that "it appears that AA has been successful with Native Americans when it has been 'Nativized' (probably to a point where it would be unrecognizable to other AAs)" (p. 18). It must also be noted that since AA was designed as a support group, certain modifications would be necessary to use it as the basis for a treatment program. Our treatment center surveys were designed to follow up on some of these issues.

Methods

The 1993 survey of vocational rehabilitation counselors (Schacht & Gaseoma, 1993) asked if they knew of an exemplary treatment center for American Indians with alcoholism or drug abuse disorders, and if so, to identify it. The target population for the 1993 treatment center survey consisted of 50 treatment centers

recommended to us by these VR counselors (Schacht & Gaseoma, 1993, Appendix C). Whether or not the treatment centers in this sample were in fact any better than other treatment centers is unknown and unprovable with the data at hand. The 1993 survey revealed that most of the treatment centers were apparently based on AA. The 1993 treatment center survey included some questions to facilitate comparison with the types of treatment centers defined by Weibel-Orlando (1989). Thirty-one of the 50 recommended treatment centers responded (62% response rate).

In 1996, a four-page follow-up survey was conducted to explore how and to what extent the same treatment centers used the philosophy and tenets of AA. The follow-up questionnaire was designed with the assistance of Curt Yazza, NCADC, CADAC, a Navajo. The follow-up questionnaire was sent to each of the 31 treatment centers that had responded to the 1993 survey; 14 responded.

1993 Survey Results

Most (18/31) of the treatment centers in the 1993 survey were located on a reservation. Twenty-nine percent were in an urban area, and one was in a rural, nonreservation location. The location of three of the centers was not specified. Almost half (14/31) were tribally operated; most of the others (12/31) were operated by the Indian Health Service (IHS). The top five treatment orientations reported were AA/Narcotics Anonymous (NA), generic outpatient treatment programs, outpatient drug-free programs, 28-day Hazelden or Minnesota model inpatient treatment programs, and Native American traditional healing. Most (16/31) of the centers had been operating for more than 12 years, with a range of 3 to 30 years, and offered both residential and outpatient treatment (17/31). For 27 of the centers, treatment of alcoholism and drug abuse was their main service. The number of counselors involved in the treatment of American Indians or Alaska Natives (AI/AN) varied from 2 to 16, with a mode of 9. The percentage of counselors who were Native American varied from 3% to 100%. In most cases (25/31), at least

half were AI/AN. The tribal affiliations of the counselors varied, but most of the time (20/31), at least half of the counselors were from one tribe. The most common tribal affiliations when most of the counselors were from one tribe were Sioux (n = 5), including Sisseton-Wahpeton Dakota and Assiniboine/Sioux, Chippewa/Ojibwa (n = 3), and Northern Cheyenne (n = 2).

Each treatment center was evaluated by type and compared with the frequency of program types in Weibel-Orlando's (1989) study. Together, the culture-sensitive and syncretic program types (the most "Indian" types) constituted 90% of the 1993 sample of treatment centers, compared with 69% of Weibel-Orlando's (1989) sample.

Each treatment center reported clients at widely varying stages in their recovery process, from denial through contemplation, preparation, and recovery (or *action* followed by *maintenance*; cf. Prochaska, DiClemente, & Norcross, 1992). Before treatment, the largest number were reported to be in either the contemplation or preparation stage. However, these same programs also reported some clients who were still in denial (sometimes these were court-ordered referrals), and others who were already in recovery and had been abstinent for some time. Even during treatment, similar ranges of clients were reported, with of course more clients who had been in recovery for a longer period of time.

Success Rates

Each center was asked what percent of their American Indian/Alaska Native clients could be regarded as "successfully rehabilitated." Responses ranged from 1% to 95%, with an average of 45%. The centers were also asked which treatment best characterized their overall orientation. We compared the average success rate for each *orientation* with the average success rate for *treatment centers that did not have that orientation*. None of the treatment orientations had a statistically significant edge over the others. The highest success rate for an orientation was 76%, for the *Native American Church*; however, only one program had this orientation. *Employee assistance programs* (n = 2, 74.5%) and *psychiatric and psychological model programs*

(n = 4, 61.5%) also had high success rates, but few programs had these orientations either. The success rate for programs with an *AA/NA (outpatient)* orientation, which was the most popular (n = 20), averaged only 43%. Other treatment orientations claimed success rates averaging from 41.3% for the *outpatient drug-free program* (n = 17) to 48.4% for the *Hazelden/Minnesota model* (n = 18). The average success rate claimed by *Native American traditional healing programs* (n = 15) was 45%.

1996 Survey Results

The 14 treatment centers that responded to the 1996 follow-up survey came from nine states. The distribution of responses was very similar to the 1993 survey, except that no responses were received from five of the original states. Half of the treatment centers indicated that "most of" their treatment methodology was based on AA. The rest indicated that "some" of their treatment methodology was based on AA. Most of them (71%) required attendance at AA meetings as part of their treatment method, and the remainder indicated that attendance was recommended. The average number of meetings was about six per month. Attendance at AA meetings was "always" (86%) or "usually" (14%) a part of their aftercare recommendations.

Most of the treatment centers (64%) reported that their clients did not experience significant cultural barriers to their participation in AA. Of the previously identified cultural barriers to the use of AA by Native Americans (Leland, 1980), the most significant was "public discussion of personal problems," with half of the treatment centers indicating that it was an important or significant barrier, and half indicating that it was not. Six of the 14 (43%) thought that "efforts to influence other people's behavior" and "dominant society religious overtones" were problems. Most of the treatment centers (86%) said that their clients did *not* feel that AA meetings were too religious. The requirements for abstinence and for the exclusion of nonalcoholics were not considered important cultural barriers.

Half of the treatment centers reported that their use of AA has stayed the same over the years, 29% said they were integrating

more of it in recent years, and the remainder were more ambiguous in their responses. Because Leland (1980) suggested that the most successful programs had "Nativized" their treatments, each center was asked if they did this: Half responded positively. This Nativization was achieved in a variety of ways, with the most common method being sweat lodges (four centers). When used, these were offered at Steps 3, 6, or 11 of AA's Twelve Steps (see Appendix A). Meditation was used at three centers. Step 11 explicitly involves meditation, but some centers use it earlier (e.g., in Steps 6 and 7), and others do not get that far in treatment. Two centers used the *medicine wheel*.

The Twelve Steps

All 14 treatment centers used the first four steps of AA, 13 centers used the first five steps, and 9 used all 12 steps. However, two centers did more picking and choosing: One used Steps 1–5 and 12; another used Steps 1–5, then 7 and 8, and then 12. A big factor in how many steps were used was how long the client was in treatment; that is, most were not in treatment long enough to advance past Step 5. The Twelve *Traditions* of AA, which govern how AA meetings should be organized and run, were not as well known and were not used as much as the Twelve *Steps*.

Conclusions

In summary, the exemplary alcoholism treatment centers for American Indians that we surveyed were programs that extensively incorporated American Indian personnel and cultural practices into their treatment process. Ninety percent of these were the program types deemed most "American Indian" according to the Weibel-Orlando categories described earlier. All of the programs used some part of the AA philosophy, and most could be considered to be based on AA. However, even amongst these exemplary programs, success rates over 50% were rare. Programs with a treatment orientation based on Native American traditional healing did not claim success rates significantly higher than other treatment orientations ("success" was self-defined).

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COUNSELOR FOCUS GROUPS

The purpose of this activity was to elicit information not likely to be obtained from questionnaires from VR counselors who had worked with American Indian or Alaska Native clients with alcohol or drug problems. The open-endedness of responses to focus group questions, plus the interaction among participants in stimulating more far-ranging information about counselor-client interactions, resulted in information that complements the responses to written questionnaires. The results of these discussions were then compared with client focus groups to identify areas of disagreement or differences in attitudes and beliefs.

Methods

Counselor focus groups of 6–12 participants were conducted in three states: Texas, New Mexico, and Arizona. The counselors from Arizona and Texas were primarily Anglos; the New Mexico counselors, however, were primarily American Indians (mostly Navajo). The protocol that was developed for all three focus groups consisted of a set of primary questions, each accompanied by follow-up questions used on an ad-hoc basis to stimulate additional discussion if needed. Thus, all primary questions were asked of each focus group, but use of the follow-up questions varied from group to group, as needed. The meetings were tape recorded and transcribed for each group. The transcripts were then analyzed using Tally 4.0 (Bowyer, 1991). Each question from the interview protocol was assigned a mnemonic that was used to code the discussion of that particular question. In addition, submnemonics were created to identify specific topics within the focus group conversations. This facilitated the analysis of the discussions by topic.

Results

Eligibility

One common theme concerned the application process for vocational rehabilitation services. Vocational rehabilitation counselors in Arizona and Texas thought it took too long; in Têxas, it might take a month or two just to get an appointment with a VR counselor. Some of the Texas and New Mexico counselors thought that this was not necessarily a bad thing,

because it would show who was really serious about applying. On the other hand, some potential clients just give up. Another recurrent theme concerned alcohol abuse as a secondary disability. Counselors in all three states reported that in some cases they were not aware that a client had an alcohol abuse problem until VR was already in process, and then it could create problems (e.g., the client missing an appointment). The counselors felt a lack of guidelines on how to deal with this problem. Some argued for immediate confrontation; others argued for suspending VR until the alcoholism was in remission. Others wondered how to tell when the problem was, in fact, in remission.

Rehabilitation

VR counselors in Arizona and especially New Mexico thought that dealing with their alcoholic clients required more time and effort than with many other clients, but that this effort was usually worthwhile. However, they also noted that with big caseloads, this extra effort was often not possible. Counselors in Arizona and Texas also mentioned the importance of family support in rehabilitation, while recognizing that if the family included other alcoholics, it could lead to more problems. They recognized that this was a common occurrence.

Abstinence vs. Abuse

One of the biggest differences between abstinent and abusing clients was apparent in their ability to make goals and plan effectively. This involved strategies other than alcohol for dealing with life's problems. One consequence of this is that the counselors felt that abstinent clients were more dependable.

Stages of Change

All of the participants in the focus group sessions were given a handout describing five stages of change in the recovery process (Prochaska, DiClemente & Norcross, 1992). They were then asked to discuss the earliest stage at which an applicant would be ready to benefit from VR services. The Arizona VR counselors, along with several from New Mexico, agreed that Stage 4 was the earliest (*action: actively engaged in changing behavior successfully, but for less than six months; success criteria may*

include abstinence or sobriety), but one New Mexico VR counselor and several Texas VR counselors felt that Stage 3 (*preparation: ready to take action in the next 30 days; may have unsuccessfully taken action in the past year; may have achieved some reductions in problem behaviors*) was the earliest they would accept someone, while admitting that Stage 4 was more realistic. Many counselors, especially those from New Mexico, noted that some clients came into VR while they were in Stages 1 (*pre-contemplation*) or 2 (*contemplation*), but that they did not get beyond applicant VR status until they were in Stage 3 or higher.

Motivations

All three groups of counselors agreed that seeing their clients succeed and make positive changes was one of the things that motivated them the most. But one of their pet peeves was dealing with the denial and the manipulative con games of clients who were not abstinent.

Training Modules

Counselors in Arizona and Texas wanted more training in cultural sensitivity issues, including those concerning impoverished clients. Counselors in New Mexico, who were mostly American Indians, wanted more training in technical subjects such as theories of client change, 12-step programs, and alcoholism as a disease.

Conclusions

Counselors agreed that there was a need for awareness about how to deal with alcoholism when it shows up as a secondary disability during VR services. They also agreed that the process of application and eligibility determination takes too long, although in some cases this may not be a bad thing. Most agreed that although it is best for a client to be in recovery before receiving VR services, counselors must be prepared to deal with clients in every stage of recovery. Finally, they all agreed that one of the most motivating things is to see a client experience success and positive change.

COUNSELOR SURVEY

Our interest was to survey counselors who had worked with at least five American Indian or Alaska Native clients during the past year who were eligible for VR services and for whom alcohol or substance abuse or dependence was a primary, secondary, or tertiary disability.

Methods

The survey instrument, which was developed by the project staff, was pilot-tested face-to-face with three VR counselors in Texas. The questionnaire was then finalized and letters of invitation were mailed to more than 100 VR counselors across the country. Telephone follow-up calls were made to VR counselors or their supervisors to determine whether or not they met the caseload criteria and were interested in participating in the project. If they agreed to complete the questionnaire, the survey was mailed to the VR counselor.

The types of questions in the survey included sociodemographic characteristics and background of counselors; special issues around client eligibility for VR services; caseload characteristics, counseling activities, and barriers to implementation of VR services for American Indian clients; client characteristics including intention to change addictive behavior; perceived training and background needs for self and other VR counselors; views on what makes an effective alcohol or drug treatment program for American Indian clients; and perspectives on aftercare and maintenance therapy for clients. All of these areas are briefly summarized.

Results

A total of 32 VR counselors from 10 states completed the follow-up survey (response rate 30%). Of these 32 individuals, 63% were male and 37% were female; the most common age was between 40 and 49; and 50% were Anglo, 40% were American Indian, and 10% were Hispanic. Slightly over half (55%) of the counselors had master's degrees. Twenty-five counselors reported working for State Rehabilitation Services Administration programs and seven counselors worked for tribally operated Section 130 VR projects. The counselors

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reported working an average of 8 years as a VR counselor. In addition, five counselors had worked an average of 5 years as an alcoholism counselor. Counselors indicated that they had counseling certification or training and experience in a wide range of areas, but most notably rehabilitation and alcoholism or drug abuse. Six of the counselors identified themselves as recovering alcoholics.

With regard to special issues for AI/AN clients, 63% (15 state VR counselors and 5 Section 130 VR counselors) thought that these clients were as successful in becoming eligible for VR services as non-Indians. The top five factors listed as contributing to eligibility problems for these clients included lack of transportation, lack of follow-through by client, cultural differences, lack of trust, and confusion about eligibility.

Counselors were asked to describe their client caseload characteristics within the past year. They reported having an average of 8.40 AI/AN clients with a primary, secondary, or tertiary disability of alcoholism or drug abuse who became eligible for VR treatment. There were no differences in caseload characteristics by counselor ethnicity, counselor educational level, or counselor certification. Counselors were also asked to describe their counseling activities with their AI/AN clients during the last 30 days. The five activities rated as most important in working with these clients included showing concern and empathy, encouraging acceptance of responsibility and self-reliance, defining long-range goals, specifying short-term objectives, and increasing the level of rapport and trust.

Counselors were asked to indicate whether special needs for services existed for AI/AN clients with alcohol or drug disorders and to describe the barriers that they felt prevented implementation of the special services. Some of the special needs that arose with regard to maintenance of services included the ability to obtain diagnostics, financial assistance, access to a halfway house, a centrally located treatment center, positive role models, and more education for families. Barriers to the implementation of maintenance services included limited

resources, distrust of physicians, not being able to afford specialized follow-up treatment, rigid state and federal laws that prevent helping certain individuals, paperwork, transportation, and lack of client follow-up on treatment plans. Other areas of special need included on-the-job training, business or vocational training, and college or university training. Each of these had their own barriers to overcome, but some common issues raised by all included lack of awareness of services and programs, lack of client follow-through, lack of transportation, client relapses, and discrimination by non-Indians.

In describing how alcohol or drug abuse was affecting their clients' lives, counselors identified five main issues: alcohol or drug use was causing problems with family or friends, they want to get their lives straightened out, alcohol or drug abuse was a problem for them, alcohol or drug abuse was causing problems with the law, and they need help in dealing with their alcohol or drug use. Counselors also described many of their clients as having one or more alcoholic parents, having difficulty with relationships, and being involved with both social and binge drinking. Counselors were asked to describe the perceived state of mind of their clients prior to reaching VR case management Status 10 (eligibility) versus after reaching Status 10. Counselors reported that prior to reaching Status 10, most of their clients were still learning about the nature of the addictive behavior. After reaching Status 10, counselors felt that most of their clients were aware that a problem with alcohol or drug use existed and that the client was seriously thinking about dealing with the addiction.

Of the 32 respondents, 17 had a university degree and a training background that was medically oriented. Eleven counselors reported a training background as being "mixed" (any combination of certification seminars and on-the-job training). The remaining four counselors indicated mostly on-the-job, life experiences, and some Indian healing practices. In addition, 16 counselors reported having had training in alcohol or drug abuse counseling; 10 indicated that they would like more training in

this area, and 6 reported that they had never received any training in alcohol or drug abuse counseling. Counselors were also asked to provide information they felt would help them to make better use of supportive services in developing the Individual Written Rehabilitation Plan (IWRP) to improve chances for successful rehabilitation. They identified the following areas: relapse prevention, *Fetal Alcohol Syndrome* (FAS), information concerning eligibility for supportive services, information related to cultural needs to better understand cultural differences, information about financial aid resources offered by specific agencies, information about culture-sensitive evaluation and testing, and more knowledge about client support systems including family ties, beliefs, and customs.

Counselors were asked to rank the treatment programs available in their respective areas for American Indian clients. They regarded *AA/NA, spiritual or religious programs,* and *American Indian healing programs* as the three most effective approaches. When counselors were asked how they defined successful rehabilitation, most reflected a relationship between a client's sobriety, employment, length of sobriety and employment, and other supportive factors. Counselors were also asked to identify aftercare programs that were most important in helping these clients maintain sobriety or abstinence. The programs included AA, NA, halfway houses, treatment centers for AI/AN, outpatient services for client therapy, group and individual counseling, spiritual leaders in the community, the church, and referrals to an alcohol or drug center.

Counselors were questioned about client, community, and sociocultural barriers to aftercare and how counselors might overcome some of these barriers to help clients reconnect with family, community, or other support networks. Perceived barriers to aftercare participation included lack of trust, lack of understanding, resistance or embarrassment with seeking help, and lack of transportation. Community barriers that were mentioned included lack of community education concerning programs, community denial, community shame, and

indifference to alcoholism. Counselors also mentioned family and friendship barriers to aftercare, including the influence of family and friends who were still drinking. Several counselors indicated that the type of assistance they provided to the client to help them reconnect with support networks included giving referral information to clients about support systems, trying to build support networks into the plan of services, and referring clients to local American Indian resource groups. One respondent indicated that involvement of a Native ceremony to reconnect family unity and having a medicine man talk to the family could prove to be important aftercare support.

Client Focus Groups

The purpose of this activity was to elicit information not likely to be obtained from questionnaires from American Indian or Alaska Native VR clients who had alcohol or drug problems. The open-endedness of responses to focus group questions, plus the interaction among participants in stimulating more far-ranging information about counselor-client interactions, resulted in information that complements the responses to written questionnaires.

Methods

Client focus groups of 6–12 participants were conducted in three states: Texas, New Mexico, and Arizona. The protocol that was developed for all three focus groups consisted of a set of primary questions, each accompanied by follow-up questions used on an ad-hoc basis to stimulate additional discussion if needed. The meetings were tape recorded and transcribed for each group. The transcripts were then analyzed using Tally 4.0 (Bowyer, 1991). Each question from the interview protocol was assigned a mnemonic that was used to code the discussion of that particular question. In addition, submnemonics were created to identify specific topics within the focus group conversations. This facilitated the analysis of the discussions by topic.

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Results

Eligibility

The focus groups in Texas and New Mexico thought that one barrier to eligibility sometimes was lack of follow-up by the *client*. In addition, a wide variety of other possible barriers to eligibility were discussed, including the length of time it takes to determine eligibility, cancellation of appointments by the *counselor*, lack of transportation, and client relapse due to frustrations with any of these barriers.

Rehabilitation

The focus groups in Texas and Arizona had some concerns about differences between clients and counselors in understanding the VR process. These two groups also discussed the problem of relapse and the difficulties of maintaining sobriety. Finally, some clients felt abandoned by their counselors after they got a job.

Abstinence vs. Abuse

Topics brought up by participants with respect to this question were the ability to think ahead and plan, the influence of friends, the importance of religion, and employment. Thus, an abstinent client was one who thinks ahead and makes plans to improve life, stays away from friends who drink, attends AA or NA meetings, is involved in religion, and is employed. The client who is still abusing alcohol is portrayed as the mirror image of these things.

Stages of Change

All of the participants in the focus group sessions were given a handout that described five stages of change in the recovery process (Prochaska, DiClemente & Norcross, 1992). They were then asked to discuss the earliest stage in which an applicant would be ready to benefit from VR services. The Texas focus group agreed that a person should not begin VR until in the fifth stage (*maintenance: continuous, successful behavior change lasting for more than six months; key features are avoiding relapse and stabilizing behavior change, while maintaining sobriety*). However, the other focus groups could not come to any agreement about this question. The Arizona clients did agree that as long as someone was still involved in their addictive behavior,

he or she could not benefit from VR services. This would appear to eliminate the first two stages (*pre-contemplation* [denial] and *contemplation*) and possibly the third stage (*preparation*, which may include several unsuccessful attempts at sobriety).

Motivations

Although it is not easy to generalize about client responses on this subject, some helpful points included the counselor's faith in the client's ability to change, finding out what their strengths were and what they could do well, having the support and encouragement of their counselor, family and friends in a familiar cultural environment, and maintaining contact with their counselor. Pet peeves included counselors who disrespect them, stare at them like they're hiding something, change appointment dates, refer them to another counselor without their knowledge, or make them wait.

Training Modules

The New Mexico clients had the most to say about this subject. Their concerns included decreasing the amount of paperwork in the application process, which they associated with the length of time it takes to become eligible, making the therapeutic relationship more serious, and improving the working relationship between client and counselor. These last two points may be related, when considering for example impersonal appointments with the counselor where the sole purpose is to sign papers. A client characterized this as "sign and dash" therapy.

CLIENT SURVEY

This VR client questionnaire was designed to mirror some of the questions addressed with the VR counselors, in order to identify areas where counselors and clients had significantly different viewpoints on the rehabilitation process, as well as to identify problem areas perceived by both counselors and clients.

Methods

The questionnaires were distributed to clients in two main ways: At the end of focus group meetings in Arizona, New Mexico, and Texas, clients could fill out the questionnaire on the spot and give them to us before we left the site, or they could take

the questionnaire home with them and return it later. Also, questionnaires with self-addressed, stamped envelopes were mailed to VR counselors who had cooperated with the counselor survey. They were asked to distribute the questionnaires to any clients with disabilities of substance abuse or alcoholism, to allow the clients to complete the forms privately, and to mail the questionnaires back in the envelopes provided, respecting the confidentiality of the responses.

Results

Responses were received from 24 American Indian clients using state and tribal VR services. The clients, most of whom were male (83%), came from five states, were affiliated with 15 tribes, and were most commonly between the ages of 30 and 39. They had a mean educational level of 11.5 years, and most were (92%) recovering alcoholics. Seventy-five percent of the VR clients interviewed were involved in Alcoholics Anonymous and the majority of these felt that AA was a very valuable part of their recovery. Seventeen percent found help in Native American spirituality, sweat ceremonies, and family support. Another 17% received help from their VR program or counselor. When asked about drinking habits of their family members, 80% reported that their friends abused alcohol or drugs, 46% stated that family members other than their parents or grandparents abused alcohol or drugs, and 25% reported that one or more of their parents or grandparents abused alcohol or drugs. *High stress levels, difficult relationships,* and *binge drinking* were reported frequently.

Most clients said that when they *first* entered the VR program, they were seriously thinking about dealing with their addiction and were ready to take action in the next month about their addiction, but had thus far not been very actively engaged in behavioral change. When clients were asked to describe their *current* state of mind regarding their alcohol or drug abuse problem, more were ready to take action and were actively involved in changing their behavior; more clients also indicated

that it was easier to talk with their counselor about their addiction.

As with the counselors, clients were asked how alcohol or drug abuse was affecting their lives. The top five answers included that they wanted to get their lives straightened out, alcohol or drug use was causing problems with their family or friends, alcohol was making life worse and worse, alcohol was more trouble than it was worth, and they needed help in coping with alcohol use.

With regard to clients' perspectives on the VR system, most clients (42%) said that they preferred a rehabilitation counselor; 38% said that they preferred a counselor from their own tribe and 71% preferred a counselor who was a recovering alcoholic. Others also stated that the counselor needs to be a person who can get things done, who is understanding and open-minded, and who can help with providing training for jobs with currently available resources. Clients reported that the way counselors helped them the most was by providing an atmosphere of understanding and compassion. Perceived areas of inadequacy in VR counselors included allocation of funds, keeping appointments, interest in long-term progress, being available, and so forth.

Only 29% of clients (as compared to 63% of counselors) thought that AI/AN clients were as successful in VR as non-Indian clients. The top five factors listed as leading to unsuccessful rehabilitation included lack of transportation, lack of follow-up by client, cultural differences, lack of follow-up by counselor, and counselor's judgment that the client would not benefit from services. As with the counselors, clients were asked to what extent certain activities were taking place during their meetings with counselors. The five activities considered to be most representative of issues raised during counseling sessions included accepting responsibility and self-reliance, defining long-range goals, specifying short-term objectives, building confidence, and getting specific advice and guidance.

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Clients found a wide range of treatment programs to be most helpful. Some preferred Indian treatment centers using some Native practices, some preferred group therapy, and some said that AA helped the most. Eleven of the clients defined successful rehabilitation as the ability to "stay clean." Seven other clients defined it as the ability to maintain a job. Three clients indicated that reaching educational goals was a part of successful rehabilitation. Half of the clients indicated that family members or significant others in their lives were not involved in their rehabilitation program, whereas the other half indicated family support. In addition, 62% said that they had various support systems beyond the family.

When clients were asked what program was most important to them in maintaining sobriety, 43% stated that AA was most important. Other approaches noted were one-to-one counseling, group therapy, support from non-using friends, and a program with other recovering American Indians. With regard to community or cultural barriers to aftercare, several clients suggested that alcoholics are stigmatized within their community.

EXECUTIVE SUMMARY CONCLUSIONS

Although Alcoholics Anonymous is a support group, not a treatment program, it has become so commonplace that its language and assumptions about alcoholism provide a constant point of reference for people other than alcoholism professionals. Even in treatment programs, usage of the AA paradigm was more often true than not. And yet, some common features of AA, such as public discussion of personal problems, were problematic. The main point may be that there is no widely known significant rival to the AA way of talking about alcoholism.

Both clients and counselors agreed that the process of application and eligibility determination takes too long. They also agreed that it is best for clients to be in recovery to benefit the most from services, that exceptions to this rule for one reason or another are common, and that counselors must be ready to deal with clients in every stage of recovery.

Overall, there were a number of areas of congruence in counselor and client perspectives; however, there were also some areas of disparity. For example, only 29% of clients (as compared to 63% of counselors) thought AI/AN clients were as successful in VR as non-Indian clients. While both clients and counselors listed "lack of follow-up by client" as being a main deterrent to successful VR eligibility of American Indian clients, more clients thought that the counselors perceived that clients would not benefit from services. VR counselors rated their clients' drinking problems much higher than the clients did, and underestimated the amount of stress and relationship problems that their clients experienced. Clients were more optimistic about their ability to get help in treatment than the counselors thought they were. When asked about aftercare programs, both groups answered that AA was the most important mechanism in place; but counselors also said that these programs did not fit the personal needs of their clients and that there was a distrust of available program services. The clients' perspective was that they [the clients] felt stigmatized within their communities. Finally, 30% of the clients indicated that involvement in ceremonies or sweats was an important cultural factor supporting aftercare. Several counselors, however, did not know how to respond to this question. These and the other differences summarized above indicate that clients and counselors often see things differently and are unaware of these differences. There is an apparent need to provide additional culturally tailored training for VR counselors in the areas of treatment and aftercare approaches for American Indian clients.

Recommendations

In reviewing these results, several recommendations can be made.

- Time spent determining eligibility, and then beginning IWRP development, should be reduced as much as possible because client recovery is often fragile in the initial stages, when delays can sabotage their efforts to maintain sobriety. Counselor

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contact and visible signs of progress in VR can enhance client motivation; delays and lack of contact can be discouraging.

- If a psychological assessment is needed as part of eligibility determination, the examining psychologist should have experience dealing with American Indians and with persons with alcoholism or drug abuse or dependence, and should take time to establish a rapport with the client before asking personal questions.

- VR counselors should be trained to use one or more short alcoholism screening instruments (such as the CAGE or the MAST short form) or should develop other methods to screen clients for signs of alcohol or drug abuse or dependence as a secondary disability. Affected clients may be in any of the stages of recovery.

- Whenever possible, clients who have alcoholism or drug abuse or dependence should work with counselors who have training in that area. Communication is enhanced further if the counselor has "been there" and is now "in recovery," rather than depending on "book learning." VR counselors must be prepared to deal with clients in any of the stages of recovery.

- Alcoholics Anonymous is a support group, and should not be used as a substitute for a treatment program. VR counselors who have clients with alcoholism or drug abuse or dependence should familiarize themselves with the principles and practices of AA, as well as the various AA groups in the client's home area, in order to make an appropriate referral. Such factors as ratio of Native Americans to non-Natives, and whether or not the client can find a suitable AA sponsor, can make a difference in the value of AA as a support group. If attendance at AA meetings is a part of the IWRP, the VR counselor should talk with the client on a regular basis concerning the AA meetings.

- Stereotypes about drunken Indians and hopelessness about the rehabilitation of American Indians with alcoholism or drug abuse or dependence are not warranted. Clients were more

optimistic about their ability to get help in treatment than the counselors thought they were.

- Finally, as can be said about many other aspects of vocational rehabilitation, smaller caseloads (allowing more time to spend with each client), quicker and more timely access to VR counselors, counselor initiative, and training in the client's disability contribute to success.

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Appendix A

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

Study of these Steps is essential to progress in the AA Program. The principles they embody are universal, applicable to everyone, whatever his or her personal creed. In Alcoholics Anonymous, we strive for an ever-deeper understanding of these Steps, and pray for the wisdom to apply them to our lives.

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1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.

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